

RIDGEWOOD ORTHOPEDIC GROUP L.L.C.

Today's Date: ___/___/___

Patient's Name:			Patient's Age:
Last	First	M.I.	

REFERRING / MEDICAL DOCTOR: _____

Please Describe why you are seeing one of our doctors:

 Follow up for previous visit, or new problem: _____**Please indicate any current or past Medical Problems since your previous appointment in this office.**

	No	Yes	If YES, please describe
EYES	No	Yes	
EARS/ NOSE/ THROAT	No	Yes	
LUNGS/ RESPIRATORY/APNEA	No	Yes	
STOMACH/ DIGESTION	No	Yes	
BOWELS/ INTESTINAL	No	Yes	
BLADDER	No	Yes	
DIABETES	No	Yes	
BLOOD PRESSURE (High/ Low)	No	Yes	
BLEEDING	No	Yes	
BALANCE/ DIZZYNESS	No	Yes	
BLACKOUTS/ FAINTING	No	Yes	
NUMBNESS/ TINGLING	No	Yes	
PSYCHOLOGICAL/ EMOTIONAL	No	Yes	
AIDS/TUBERCULOSIS	No	Yes	
CANCER	No	Yes	
ARTHRITIS	No	Yes	
POLIO	No	Yes	
ENDOCRINE/THYROID	No	Yes	
EPILEPSY/ SEIZURE DISORDER	No	Yes	
STROKE/ HEART	No	Yes	
MULTIPLE SCLEROSIS/ LUPUS	No	Yes	
OTHER	No	Yes	

List any hospitalizations or surgeries since your last appointment at this office

Type of Hospital Illness or Surgery	Year	Any Complications

SOCIAL HISTORY

() EMPLOYED [occupation] _____

() WORK AT HOME () STUDENT () Single () Married () Separated () Divorced () Widowed

DO YOU HAVE CHILDREN? () No () Yes How Many? ____ DO YOU LIVE ALONE? () No () Yes

DO YOU EXERCISE? () Daily () Weekly () Monthly () Rarely () Never

WHAT TYPE OF EXERCISE? _____

ARE YOU ON A SPECIAL DIET? () No () Yes - Describe: _____

ANY HISTORY OF SUBSTANCE ABUSE? () No () Yes - What kind? _____

DO YOU DRINK ALCOHOL? () No () Yes - How much, how often? _____

DO YOU CURRENTLY SMOKE? () No () Yes _____ packs per day for _____ years

IF YOU HAVE QUIT, HOW LONG HAS IT BEEN? _____ weeks _____ months _____ years

HOW MUCH DID YOU USED TO SMOKE? _____ packs per day for _____ years

REVIEWED BY: Dr. _____ DATE: ___/___/___